



United States Government Accountability Office
Washington, DC 20548

May 28, 2008

The Honorable Daniel Inouye
Chairman
The Honorable Ted Stevens
Ranking Member
Subcommittee on Defense
Committee on Appropriations
United States Senate

The Honorable John P. Murtha
Chairman
The Honorable C. W. Bill Young
Ranking Member
Subcommittee on Defense
Committee on Appropriations
House of Representatives

Subject: *Review of the President's Fiscal Year 2009 Budget Request for the Defense Health Program's Private Sector Care Budget Activity Group*

The President's budget request for the Department of Defense's (DOD) Defense Health Program has increased steadily in recent years.¹ For example, from fiscal year 2005 to fiscal year 2009, the budget request for the program increased from about \$17.6 billion to about \$23.6 billion, an increase of about 34 percent. DOD has attributed a majority of this increase to growth in medical care, dental care, and pharmaceuticals provided in the private sector to active duty personnel and other eligible beneficiaries.² These private sector expenses are funded through the Defense Health Program's Private Sector Care Budget Activity Group (BAG).³ From fiscal year 2005 to fiscal year 2009, the budget request for this BAG increased by about 36 percent—from about \$9.0 billion to almost \$12.2 billion.

¹The Defense Health Program account is established under 10 U.S.C. Sec. 1100 and is funded by a separate Defense Health Program account appropriation every year in the Department of Defense Appropriations Act. In addition to appropriations, the Defense Health Program account contains other sources of spending authority, such as offsetting collections, which are funds collected by the government that are required by law to be credited directly to an expenditure account.

²DOD provides these health care services through its TRICARE program.

³Budget Activity Groups represent major programs within the Defense Health Program.

Report Documentation Page				Form Approved OMB No. 0704-0188	
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1. REPORT DATE 28 MAY 2008		2. REPORT TYPE		3. DATES COVERED 00-00-2008 to 00-00-2008	
4. TITLE AND SUBTITLE Review of the President's Fiscal Year 2009 Budget Request for the Defense Health Program's Private Sector Care Budget Activity Group				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S)				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) U.S. Government Accountability Office, 441 G Street NW, Washington, DC, 20548				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution unlimited					
13. SUPPLEMENTARY NOTES					
14. ABSTRACT					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT Same as Report (SAR)	18. NUMBER OF PAGES 23	19a. NAME OF RESPONSIBLE PERSON
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified			

The Conference Report accompanying the Fiscal Year 2008 Department of Defense Appropriations bill directed us to review the President's fiscal year 2009 budget request for the Defense Health Program's Private Sector Care BAG.⁴ To do this, we reviewed (1) DOD's justification for the request for the Private Sector Care BAG, including the underlying estimates and the extent to which DOD considered historical information; and (2) changes between this request and the request for fiscal year 2008 and factors causing these changes.

To conduct our work, we analyzed the methodologies that DOD used to develop the budget requests for the Private Sector Care BAG in fiscal years 2008 and 2009. We also interviewed officials and analyzed documents from DOD's Office of the Under Secretary of Defense (Comptroller) and TRICARE Management Activity, which were the offices responsible for developing budget requests for the Private Sector Care BAG. We also relied on prior GAO work, particularly past work in which we analyzed DOD's projected savings from planned increases in beneficiary cost sharing.⁵

In addition, we reviewed budget and obligation data related to the Defense Health Program but we did not validate these data.⁶ We have raised concerns about the quality of DOD's financial data in previous reports.⁷ However, we determined that these data were sufficiently reliable to understand DOD's budget formulation process and the underlying assumptions used to develop the President's budget request. We based our determination on interviews with DOD officials and an examination of the data for obvious errors and omissions. We conducted this audit from January 2008 to May 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. A detailed description of our scope and methodology is listed in enclosure I.

Results in Brief

DOD based the President's fiscal year 2009 budget request of almost \$12.2 billion for DOD's Private Sector Care BAG on models and cost projections that used historical data. The department developed the budget request through a two-step process. The first step involved building an initial budget estimate, which was largely based on fiscal year 2006 data that were adjusted using trend models to reflect changes in the number of TRICARE users, utilization (i.e., health care usage per user), and costs. The second step resulted in a net reduction of almost \$2.2 billion to the initial budget

⁴H.R. Conf. Rep. No. 110-434, at 355 (2007).

⁵Increases in beneficiary cost sharing refer to higher TRICARE enrollment fees, deductibles, and copayments for certain TRICARE beneficiaries. See GAO, *Military Health Care: TRICARE Cost-Sharing Proposals Would Help Offset Increasing Health Care Spending, but Projected Savings Are Likely Overestimated*, GAO-07-647 (Washington, D.C.: May 31, 2007).

⁶An obligation is a definite commitment that creates a legal liability of the government for the payment of goods and services ordered or received.

⁷See, for example, GAO, *High-Risk Series, An Update: Department of Defense Financial Management*, GAO-07-310 (Washington, D.C.: Jan. 31, 2007).

estimate of about \$14.3 billion. To do this, DOD considered various factors, including projected savings from increased beneficiary cost sharing. While DOD included appropriate factors in developing the President's fiscal year 2009 budget request for the Private Sector Care BAG, it is likely that DOD underestimated its funding needs as we do not believe that all of the cost savings DOD expects to achieve from increased beneficiary cost sharing will be realized.⁸ In addition, similar proposals in the past to increase beneficiary cost sharing have not been enacted.

The President's fiscal year 2009 budget request of almost \$12.2 billion for the Private Sector Care BAG was about \$1.7 billion higher than the about \$10.5 billion requested for fiscal year 2008. Of this increase, \$995 million was due to estimated increases in the number of TRICARE users, utilization, health care costs, and administrative costs. The remainder of this increase was due to several factors, including greater funding needs for congressionally mandated benefit changes.

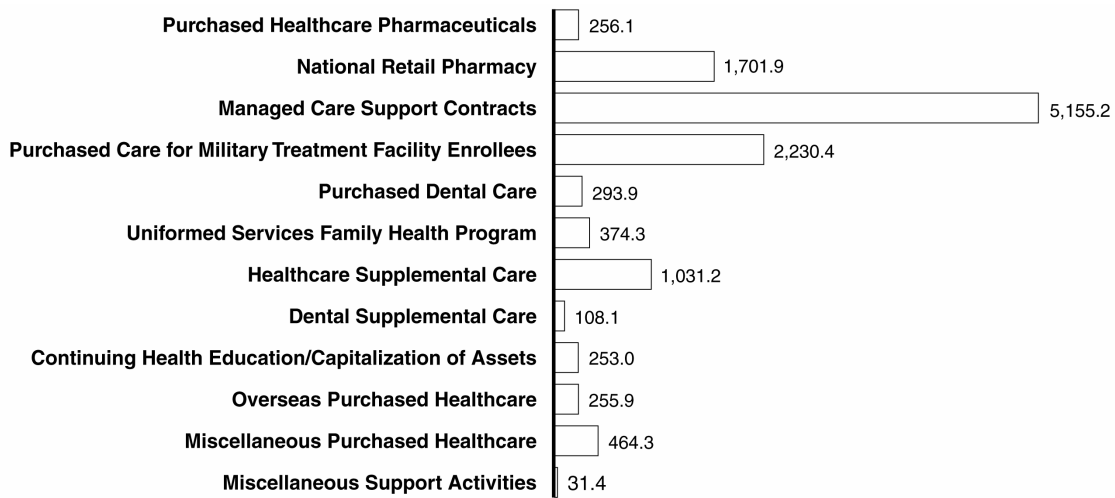
Background

DOD's Defense Health Program provides funding for medical and dental services to active duty personnel and other eligible beneficiaries, medical command headquarters, medical personnel training, occupational and industrial health care worldwide, and veterinary services. Defense Health Program funding is divided into three parts: Operation and Maintenance (O&M); Research, Development, Test and Evaluation; and Procurement. The President has requested about \$23.6 billion for the Defense Health Program for fiscal year 2009, of which about \$23.1 billion (about 98 percent) was for O&M. The O&M request was distributed into seven BAGs, including one for Private Sector Care. (See encl. II for a list and description of these BAGs.) The Private Sector Care BAG accounts for about \$12.2 billion (almost 53 percent) of the request for O&M. The budget request for this BAG is divided among 12 program elements, which are described in detail in enclosure III. See figure 1 for the amount of requested funding for each program element in the fiscal year 2009 budget request for the Private Sector Care BAG.

⁸In our prior work, we stated that projected savings from DOD's proposal to increase TRICARE cost sharing for certain beneficiaries in the form of higher enrollment fees, deductibles, and copayments are likely too high. See GAO-07-647.

Figure 1: The President’s Fiscal Year 2009 Budget Request of about \$12.2 Billion for the Private Sector Care BAG by Program Element

Dollars in millions



Source: GAO analysis of DOD data.

The Defense Health Program includes funding for TRICARE—DOD’s program that provided health care to about 7.6 million active duty personnel and other beneficiaries in 2007.⁹ TRICARE beneficiaries can elect to obtain health care either through TRICARE network or nonnetwork providers, funded through the Private Sector Care BAG, or through DOD’s direct care system of military treatment facilities, funded through the In-House Care BAG.

The President’s budget requests for the Private Sector Care and In-House Care BAGs have sometimes differed from the actual funding amounts. The President’s budget request for the Private Sector Care BAG has grown at a rate similar to the budget request for the In-House Care BAG. For example, from fiscal year 2005 to fiscal year 2008, the budget request for the In-House Care BAG increased by 16 percent compared to the 17 percent increase in the budget request for the Private Sector Care BAG. However, during that same period, funding for the In-House Care BAG increased by 26 percent compared to a 38 percent increase for the Private Sector Care BAG. The difference for the Private Sector Care BAG is because Congress funded it for \$12.3 billion in fiscal year 2008, which is \$1.8 billion more than the President’s budget request of \$10.5 billion. Congress provided this additional funding to offset projected savings associated with DOD’s proposal to increase TRICARE beneficiary cost sharing since provisions in the Conference Report accompanying the National Defense Authorization bill for Fiscal Year 2008 prevented DOD from implementing this proposal before October 1, 2008.¹⁰

⁹The Defense Health Program does not include funding for about 1.6 million Medicare-eligible beneficiaries. Costs for these beneficiaries are funded through the Medicare Eligible Retiree Health Care Fund.

¹⁰H.R. Conf. Rep. No. 110-477, at 937 (2008). Savings associated with increased TRICARE beneficiary cost sharing are also a part of the President’s budget request for fiscal year 2009.

DOD's Process for Developing the Fiscal Year 2009 Budget Request for the Private Sector Care BAG Relied on Historical Data

The President's fiscal year 2009 budget request of almost \$12.2 billion for DOD's Private Sector Care BAG was based on models and cost projections that used historical data. DOD developed the budget request through a two-step process. The first step involved building an initial budget estimate. The second step consisted of revising the initial budget estimate for the Private Sector Care BAG of about \$14.3 billion to reflect various factors, including projected savings from increased beneficiary cost sharing. This revision resulted in a net reduction of about \$2.2 billion. While DOD included appropriate factors in developing the President's fiscal year 2009 budget request for the Private Sector Care BAG, it is likely that DOD underestimated its funding needs as we do not believe that all of the cost savings DOD expects to achieve from increased beneficiary cost sharing will be realized.¹¹ In addition, similar proposals in the past to increase beneficiary cost sharing have not been enacted.

The first step in DOD's process was to develop the initial budget estimate for the Private Sector Care BAG and began in mid 2006. DOD established a baseline for the initial budget estimate by using Private Sector Care obligation data from the first 7 months of fiscal year 2006, which it annualized and adjusted for seasonal differences in health care spending. DOD officials told us that the department used part-year data because full-year data for fiscal year 2006 were not available when the budget estimate was being developed. Since DOD develops an initial budget estimate every 2 years, the initial budget estimates for fiscal years 2008 and 2009 were developed simultaneously and both used fiscal year 2006 obligation data as their baseline. This baseline represented the size of the program (or program capacity) in fiscal year 2006 whether the source of funding was from new budget authority (obligational authority) or carryover amounts.¹² Furthermore, DOD did not adjust its initial budget estimate for reprogramming actions because there were no funds reprogrammed into the Private Sector Care BAG.¹³ Hence, there were no obligations related to reprogrammed funds for the Private Sector Care BAG that occurred in fiscal year 2006.

¹¹See GAO-07-647.

¹²Budget authority is the authority provided by federal law to enter into financial obligations that will result in immediate or future outlays involving federal government funds. DOD excludes any obligations related to the Global War on Terrorism from these data because these costs are not funded through the Private Sector Care BAG. The Defense Health Program O&M appropriation allows for carryover funds, which remain available for new obligations from one fiscal year until the end of the next fiscal year. Prior to fiscal year 2008, carryover of up to 2 percent of the initial appropriation was allowed, but the Fiscal Year 2008 Department of Defense Appropriations Act limited the allowable carryover amount to 1 percent. The unobligated balance, or the portion of the budget authority that was not obligated in 2006, was not factored into the baseline because the baseline was developed using actual obligations, which are a more accurate reflection of the size of the program (or program capacity).

¹³Since fiscal year 2002, Congress has not allowed DOD to reprogram funds into the Private Sector Care BAG without obtaining prior congressional approval. H.R. Conf. Rep. No. 107-298, at 221 (2001). However, it does generally allow DOD to reprogram funds out of the Private Sector Care BAG.

To project its funding needs beyond the baseline year, DOD primarily used trend models, which projected growth in TRICARE user numbers, health care utilization, and costs.¹⁴ The department used the trend models to make adjustments to the baseline for retail and mail-order pharmacy programs and major private sector health care programs for active duty personnel, active duty dependents, as well as retirees and dependents under age 65. Together, funding needs for these programs accounted for about 80 percent of the fiscal year 2009 request for Private Sector Care BAG and largely comprised the following program elements: Purchased Healthcare Pharmaceuticals, National Retail Pharmacy, Managed Care Support Contracts, Purchased Care for Military Treatment Facility Enrollees, and Healthcare Supplemental Care. For a detailed overview of DOD's trend models, see table 1.

Table 1: Description of DOD's Trend Models Used to Develop the Initial Estimate for the President's Fiscal Year 2009 Budget Request

Model	Purpose	Description	Program element(s)
Pharmacy trend model	To project year-to-year changes in the funding needs for TRICARE's retail pharmacy system and the TRICARE Mail Order Pharmacy for active duty personnel, active duty dependents, as well as retirees and dependents under age 65.	DOD used historical data to estimate trends in the TRICARE user numbers, utilization (i.e., the average number of prescriptions per user), and the average cost per prescription.	<ul style="list-style-type: none"> National Retail Pharmacy Purchased Healthcare Pharmaceuticals
Health care trend model for active duty dependents as well as retirees and dependents under age 65	To project year-to-year changes in the funding needs for private sector health care for active duty dependents as well as retirees and dependents under age 65.	DOD used historical data to estimate trends in the TRICARE user numbers, utilization (i.e., the average number of weighted inpatient and outpatient services per user), and the average cost per weighted service.	<ul style="list-style-type: none"> Managed Care Support Contracts Purchased Care for Military Treatment Facility Enrollees
Health care trend model for active duty personnel	To project year-to-year changes in the funding needs for private sector health care for active duty personnel.	DOD used historical data to estimate trends in the TRICARE user numbers, utilization (i.e., the average number of weighted inpatient and outpatient services per user), and the average cost per weighted service.	<ul style="list-style-type: none"> Healthcare Supplemental Care

Source: GAO analysis based on DOD process.

DOD developed the initial budget estimate for the remaining 20 percent of the Private Sector Care BAG—including administrative costs, dental programs, overseas purchased health care, and other miscellaneous purchased health care programs—by

¹⁴In this report, health care utilization refers to the average number of prescriptions, weighted inpatient services, and weighted outpatient services per user. DOD weighted both inpatient and outpatient services by the relative intensity of resources required to perform each service.

using various methodologies. For example, DOD projected its funding needs for administrative costs associated with providing health care to active duty dependents as well as retirees and dependents under age 65 primarily by using data on the fees it had negotiated with its managed care support contractors and its projected health care costs for these beneficiaries. This total process resulted in an initial budget estimate of about \$14.3 billion.

The second step in developing the fiscal year 2009 budget request for the Private Sector Care BAG was to adjust the initial budget estimate for various factors. DOD officials told us they used actual obligation data from fiscal years 2006 and 2007 to make adjustments to the initial budget estimate for fiscal year 2009, which was based on actual obligation data from only 7 months of fiscal year 2006. DOD also considered the results of economic models that were developed by a DOD contractor to project growth trends in retail and mail-order pharmacy programs and DOD's major private sector health care programs for active duty personnel, active duty dependents, as well as retirees and dependents under age 65. DOD officials compared the results of the economic models with the results of DOD's trend models and decided to reduce its initial budget estimate as a result of this comparison. DOD decided to use the lower of the two projections, because the difference between them was relatively small. Table 2 lists the adjustments, including factors that were not accounted for in the initial budget estimate, such as changes in TRICARE beneficiary cost sharing. The adjustments to the initial budget estimate for the Private Sector Care BAG resulted in a net reduction of almost \$2.2 billion, bringing the fiscal year 2009 budget request to almost \$12.2 billion.

Table 2: Adjustments to the Initial Budget Estimate for the President's Fiscal Year 2009 Budget Request for the Private Sector Care BAG

Dollars in millions

Adjustment	Amount
1. Proposed changes in TRICARE beneficiary cost sharing	
Projected savings from DOD's proposed increase in TRICARE enrollment fees, deductibles, and copayments for certain TRICARE beneficiaries.	-\$1,262.1
2. Alternative projection of pharmacy and health care cost growth	
Difference between the results of economic models developed by a DOD contractor and the results of DOD's trend models.	-\$437.0
3. Revised cost projections for DOD's TRICARE Reserve Select program	
Lower than expected enrollment in the original three-tier TRICARE Reserve Select program. ^a	-\$208.3
4. Federal pricing arrangements for pharmaceuticals	
Projected savings from federal pricing arrangements for drugs purchased at retail pharmacies. ^b	-\$352.0
5. Changes to the number of active duty personnel	
Projected health care savings due to the reduction in the number of active duty personnel. ^c	-\$131.0
Projected health care savings due to the conversion of active duty medical positions to civilian medical positions.	-\$3.0
Projected health care costs associated with an increase in the number of Army and Marine Corps ground forces. ^d	\$100.9
6. Benefit changes from the National Defense Authorization Act for Fiscal Year 2007	
Projected costs for forensic exams for sexual assaults.	\$1.1
Projected costs for dental anesthesia covered by TRICARE for pediatric cases.	\$1.1
Projected costs for expansion of TRICARE Reserve Select. ^e	\$204.4
Projected savings from the prohibition on employers to offer military retirees incentives to use TRICARE.	-\$166.0
Projected costs due to the standardization of claims processing under TRICARE and Medicare.	\$39.0
Projected costs of TRICARE's disease management program.	\$27.0
7. Technical adjustments	
Technical adjustments to account for rounding.	\$0.3
Total	-\$2,185.6

Source: GAO analysis based on DOD data.

^aThrough September 30, 2007, TRICARE Reserve Select consisted of three tiers, with reservists in each tier paying different premiums based on the tier for which they qualified. The expanded TRICARE Reserve Select program went into effect on October 1, 2007. Additional projected costs for the expansion are included under item 6, above.

^bFederal pricing arrangements refer to prices made available through the Federal Supply Schedule under 38 U.S.C. § 8126. The Federal Supply Schedule price is generally available to all federal purchasers through contracts administered by the Department of Veterans Affairs. The law also requires drug manufacturers to provide brand-name drugs to the four large federal purchasers of drugs (DOD, the Department of Veterans Affairs, the United States Coast Guard, and the United States Public Health Service) at a price that does not exceed a federal ceiling price. If the Federal Supply Schedule price for a given brand-name drug exceeds the federal ceiling price, manufacturers must offer another price to the four large agencies that is at or below the federal ceiling price. The federal ceiling price does not apply to generic drugs.

^cDOD reviewed service-projected end strengths for fiscal year 2009 and identified end strength reductions for the Navy and Air Force.

¹⁴In January 2007 the President announced plans to request authority for a permanent increase in the Army and Marine Corps end strength through the Grow the Force initiative to enhance overall U.S. forces, reduce stress on deployable personnel, and provide necessary forces for success in the Global War on Terrorism. This expansion will increase the active Army's end strength by 50,000 soldiers and the Marine Corps' end strength by 19,000 marines through fiscal year 2009. In total, the Grow the Force initiative will increase the active Army's end strength by 65,000 soldiers through fiscal year 2012 and the Marine Corps' end strength by 27,000 through fiscal year 2011.

¹⁵DOD initially projected that the costs for the expansion of TRICARE Reserve Select would be \$368.6 million, but decided to decrease its projection to \$204.4 million due to lower-than-expected enrollment in the program.

Overall, we believe DOD considered appropriate factors in developing the President's fiscal year 2009 budget request for the Private Sector Care BAG for two reasons. First, DOD employed a methodology that relied heavily on historical data. These data (consisting of obligation data, TRICARE user numbers, health care utilization rates, and health care and administrative costs) provided a basis for the department to project future funding needs and adjust past cost projections. For example, DOD adjusted its cost projection for the original three-tier TRICARE Reserve Select program based on lower-than-expected enrollment in the program (see table 2, item 3). Second, the department compared the results of the DOD-developed models to project growth trends for 80 percent of the Private Sector Care BAG with alternative economic models developed by a contractor. The trend models and economic models used different methodologies for their projections but arrived at somewhat similar results. However, while DOD considered appropriate factors in developing the budget request, we have questioned DOD's projected savings from increased TRICARE beneficiary cost sharing. We have previously reported that DOD is unlikely to achieve some of its projected savings from these increases largely because we believe that DOD overestimated the number of beneficiaries that are likely to leave or not enroll in TRICARE due to these increases.¹⁵ In addition, similar proposals in the past to increase beneficiary cost sharing have not been enacted. Therefore, DOD will have underestimated its funding needs for the Private Sector Care BAG if it is unable to achieve some of its anticipated savings from increased TRICARE beneficiary cost sharing.

The Increase from the Fiscal Year 2008 Budget Request to the Fiscal Year 2009 Budget Request Was Largely Due to Projected Growth in TRICARE User Numbers, Utilization, and Costs

The President's fiscal year 2009 budget request of almost \$12.2 billion for DOD's Private Sector Care BAG was about \$1.7 billion higher than the fiscal year 2008 budget request of about \$10.5 billion. This increase was due to the following factors.

- Projected growth in TRICARE user numbers,¹⁶ projected increases in health care utilization, and projected increases in health care and administrative costs increased the budget request for the Private Sector Care BAG by about \$995 million above the fiscal year 2008 budget request.

¹⁵See GAO-07-647.

¹⁶DOD's projected growth in TRICARE user numbers includes increases in the Army and Marine Corps end strength through the Grow the Force initiative.

- Higher projected funding needs for congressionally mandated benefit changes relative to fiscal year 2008 increased the budget request by an additional \$107 million in fiscal year 2009.
- DOD's fiscal year 2009 cost savings projection for its plan to increase beneficiary cost sharing was about \$600 million lower than in fiscal year 2008, which resulted in an increase in the fiscal year 2009 budget request. Projected savings in fiscal year 2009 were lower largely because DOD has proposed a smaller increase for TRICARE enrollment fees than it had in the fiscal year 2008 budget request.
- The increases were partially offset by projected savings from federal pricing arrangements for drugs purchased at retail pharmacies.¹⁷ These savings were expected to be about \$54 million higher in fiscal year 2009 than the expected savings in fiscal year 2008.¹⁸ This increase in projected savings was due to assumed growth from fiscal year 2008 to fiscal year 2009 in DOD's retail pharmacy costs.

Agency Comments

We received written comments on a draft of this report from DOD. DOD stated that it concurs with our findings and believes that we appropriately captured the process DOD uses to develop the budget request for the Private Sector Care BAG. DOD's written comments are reprinted in enclosure IV. DOD also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of Defense and appropriate congressional committees. We will also make copies available to others upon request. In addition, the report is available at no charge on the GAO Web site at <http://www.gao.gov>.

¹⁷Federal pricing arrangements refer to prices made available through the Federal Supply Schedule under 38 U.S.C. § 8126. The Federal Supply Schedule price is generally available to all federal purchasers through contracts administered by the Department of Veterans Affairs. The law also requires drug manufacturers to provide brand-name drugs to the four large federal purchasers of drugs (DOD, the Department of Veterans Affairs, the United States Coast Guard, and the United States Public Health Service) at a price that does not exceed a federal ceiling price. If the Federal Supply Schedule price for a given brand-name drug exceeds the federal ceiling price, manufacturers must offer another price to the four large agencies that is at or below the federal ceiling price. The federal ceiling price does not apply to generic drugs.

¹⁸DOD officials told us that some of DOD's expected savings from federal pricing arrangements in fiscal year 2008 were not realized and that it is unlikely that all of the department's expected savings for fiscal year 2009 will be realized.

If you or your staff have questions about this report, please contact Denise M. Fantone at 202-512-7114 or fantoned@gao.gov or Sharon Pickup at 202-512-9619 or pickups@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff members who made key contributions to this report are listed in enclosure IV.



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Enclosures - 5

Scope and Methodology

Our objectives were to review (1) the Department of Defense's (DOD) justification for the President's fiscal year 2009 request for the Private Sector Care Budget Activity Group (BAG), including the underlying estimates and the extent to which DOD considered historical information; and (2) changes between this request and the request for fiscal year 2008 and factors causing these changes.

To analyze DOD's justification for the fiscal year 2009 budget request for the Private Sector Care BAG including the underlying estimates and the extent to which DOD considered historical information, we reviewed the analyses DOD used to develop this budget request. As part of our review, we examined how DOD (1) developed the initial budget estimate for the Private Sector Care BAG and (2) adjusted this estimate for various factors to form the President's fiscal year 2009 budget request. Specifically, we examined how DOD developed its initial budget estimate by reviewing (1) the fiscal year 2006 obligation data that DOD used as a baseline for this estimate; (2) the three models that DOD used to project cost trends for its private sector health care and pharmacy programs for active duty personnel, active duty dependents, as well as retirees and dependents under age 65; and (3) DOD's methodology for projecting the costs for the remainder of the Private Sector Care BAG. We examined how DOD adjusted the initial budget estimate to form the President's fiscal year 2009 budget request by identifying all of the changes DOD made to the estimate and analyzing the methodology DOD used to project the financial implications of these changes. We also considered related GAO reports and interviewed DOD officials in the TRICARE Management Activity (TMA) and the Office of the Under Secretary of Defense (Comptroller).¹⁹ These officials were responsible for developing the budget request for the Private Sector Care BAG.

To identify the changes from the fiscal year 2008 budget request for the Private Sector Care BAG to the budget request for fiscal year 2009 and the factors causing these changes, we reviewed the factors that DOD identified as contributing to the increase in the budget request and the dollar values associated with them.

We also reviewed budget and obligation data related to the Defense Health Program but we did not validate these data. We have raised concerns about the quality of DOD's financial data in previous reports.²⁰ However, we determined that these data were sufficiently reliable to understand DOD's budget formulation process and the underlying assumptions used to develop the President's budget request. Our assessments consisted of (1) manually and electronically checking the data for obvious errors and missing values, (2) interviewing knowledgeable DOD officials

¹⁹For example, GAO, *Military Health Care: Cost Data Indicate That TRICARE Reserve Select Premiums Exceeded the Costs of Providing Program Benefits*, GAO-08-104 (Washington, D.C.: Dec. 21, 2007) and GAO, *Military Health Care: TRICARE Cost-Sharing Proposals Would Help Offset Increasing Health Care Spending, but Projected Savings Are Likely Overestimated*, GAO-07-647 (Washington, D.C.: May 31, 2007).

²⁰See, for example, GAO, *High-Risk Series, An Update: Department of Defense Financial Management*, GAO-07-310 (Washington, D.C.: Jan. 31, 2007).

responsible for overseeing the data sources in question to determine if they had any concerns about the quality of their data and internal controls in place to ensure data quality, and (3) reviewing documentation on the data sources in question.

We conducted this performance audit from January 2008 to May 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Description of the Defense Health Program Operation and Maintenance Budget Activity Groups

The budget request for the Defense Health Program Operation and Maintenance (O&M) is distributed into seven Budget Activity Groups (BAGs). The name and description of each of the seven BAGs are below.

Budget Activity Group	Description of Budget Activity Group
In-House Care	This BAG provides for the delivery of patient care inside and outside the continental United States. The program includes inpatient and outpatient care in Department of Defense (DOD) medical centers, inpatient facilities, and medical clinics for surgical and nonsurgical conditions for military health system beneficiaries. It also provides for dental care and pharmaceuticals.
Private Sector Care	This BAG provides funds for medical and dental care plus pharmaceuticals received by DOD-eligible beneficiaries in the private sector. The BAG includes Purchased Healthcare Pharmaceuticals, National Retail Pharmacy, Managed Care Support Contracts, Purchased Care for Military Treatment Facility Enrollees, Purchased Dental Care, Uniformed Services Family Health Program, Healthcare Supplemental Care, Dental Supplemental Care, Continuing Health Education/Capitalization of Assets, Overseas Purchased Healthcare, Miscellaneous Purchased Healthcare, and Miscellaneous Support Activities. See enclosure III for additional information about these programs.
Consolidated Health Support	This BAG provides funds for seven functions which support delivery of patient care worldwide. It comprises Examining Activities, Other Health Activities, Military Public/Occupational Health, Veterinary Services, Military Unique–Other Medical Activities, Aeromedical Evacuation System, and Armed Forces Institute of Pathology.
Information Management	This BAG provides for the Information Management and Information Technology resources dedicated to the operation and maintenance of Defense Health Program facilities. This program includes the Tri-Service Information Management/Information Technology (IM/IT), Service Medical IM/IT, and Defense Health Program IM/IT Support Programs. The O&M portion of the Tri-Service centrally-managed IM/IT program funds the costs of program management, system and infrastructure sustainment, annual software licensing fees, and software and hardware maintenance fees. The Service Medical IM/IT funds noncentrally managed programs. The Defense Health Program IM/IT funds services in support of the program.
Management Activities	This BAG provides funds for Services Medical Headquarters and TRICARE Management Activity functions supporting Military Health System worldwide patient care delivery. It includes Management Headquarters, the TRICARE Management Activity, and the Business Management Modernization Program.
Education and Training	This BAG provides funds for the three primary categories that provide support for education and training opportunities for personnel with the Defense Health Program, including the Health Professions Scholarship Program, Uniformed Services

	University of the Health Sciences, and Education and Training for specialized skill training and professional development education programs.
Base Operations-Communications	This BAG provides funds for the operation and maintenance of Defense Health Program facilities. It provides for facilities and services at military medical activities supporting active duty combat forces, reserve and guard components, training, and eligible beneficiaries. This BAG includes the following: Facility Restoration and Modernization, Facility Sustainment, Facilities Operations, Base Communications, Base Operations Support, Environmental, Visual Information Systems, and Demolition/Disposal of Excess Facilities.

Source: DOD budget justification documents.

**Description of Operations Financed by Defense Health Program
Private Sector Care Budget Activity Group**

This Budget Activity Group (BAG) provides for private sector medical care, dental care, and pharmaceuticals received by Department of Defense (DOD) eligible beneficiaries. Twelve program elements make up the Private Sector Care BAG.

Program element	Description of program element
Purchased Healthcare Pharmaceuticals	This program element includes pharmaceutical costs associated with contractual pharmacy services providing authorized benefits to eligible beneficiaries via the TRICARE Mail Order Pharmacy Program.
National Retail Pharmacy	This program element includes pharmaceutical costs associated with contractual pharmacy services providing authorized benefits to eligible beneficiaries via the TRICARE Retail Pharmacy contract, which provides network pharmaceutical prescription benefits for medications from local economy establishments.
Managed Care Support Contracts	This program element funds the TRICARE Managed Care Support Contracts, which provide a managed care program that integrates a standardized health benefits package with military medical treatment facilities and civilian network providers on a regional basis. With the full deployment of TRICARE, all but a small portion of the standard Civilian Health and Medical Program of the Uniformed Services benefits have been absorbed into the Managed Care Support Contracts. This program element includes health care costs provided in civilian facilities and by private practitioners to retired military personnel and authorized family members of active duty, retired, or deceased military service members.
Purchased Care for Military Treatment Facility Enrollees	This program element includes underwritten costs for providing health care benefits to the Military Treatment Facility enrollees in the private sector as authorized under the Civilian Health and Medical Program of the Uniformed Services.
Purchased Dental Care	This program element includes the government paid portion of insurance premiums which provides dental benefits in civilian facilities and by private practitioners for beneficiaries enrolled in the Dental Program. Beneficiaries eligible for enrollment are (a) active duty family members and (b) certain reservists and their family members.
Uniformed Services Family Health Program	This program element provides TRICARE-like benefits authorized through contracts with designated civilian hospitals in selected geographic markets to beneficiaries who reside in one of these markets and who are enrolled in the program.
Healthcare Supplemental Care	This program element provides the TRICARE benefit to active duty servicemembers and other designated eligible patients who receive health care services in the civilian sector and non-DOD facilities either referred or nonreferred from military treatment facilities, including emergency care. This program element also covers health care sought in the civilian sector or non-DOD facilities due to active duty assignments in remote locations under TRICARE Prime Remote. ^a It does not cover care to active duty servicemembers stationed overseas who receive health care in the private sector, which is paid under the Overseas Purchased Healthcare program element.

Dental Supplemental Care	This program element provides for uniform dental care and administrative costs for active duty servicemembers receiving dental care services in the civilian sector, including from Veteran Administration facilities. All dental claims are managed, paid, and reported by the Military Medical Support Office.
Continuing Health Education/Capitalization of Assets	This program element provides for support of graduate medical education and capital investment within civilian facilities that provide services to the Military Healthcare System and Medicare.
Overseas Purchased Healthcare	This program element includes coverage for delivery of TRICARE benefits in civilian facilities by private practitioners to eligible active duty and active duty family members through the Global Remote Overseas Contract and foreign claims for nonactive duty beneficiaries, including Medicare eligibles. The Medicare eligibles claims are administered by the Medicare Eligible Retiree Health Care Fund. This program element also includes the Supplemental Care program, which pays for care provided overseas to active duty members.
Miscellaneous Purchased Healthcare	This program element provides for payments of health care services in civilian facilities by private practitioners not captured in other specifically defined elements. It includes administrative, management, and health care costs for Custodial Care, Special and Emergent Care Claims, Alaska Claims, Expanded Cancer, Dual-Eligible Beneficiaries Program, Transition Assistance Programs, the TRICARE Reserve Select premium-based program for Guard/Reservists and their family members, TRICARE Management Activity managed demonstrations, and congressionally directed health care programs.
Miscellaneous Support Activities	This program element provides for payments of costs for functions or services in support of health care delivery not actual health care. Contracts for marketing and education functions, claims auditing, e-Commerce, and the National Quality Monitoring Service are reflected in this program element.

Source: DOD budget justification documents.

*TRICARE Prime Remote and TRICARE Prime Remote for Active Duty Family Members are managed care options for active duty service members and their eligible family members while they are assigned to remote duty stations in the United States.

Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAY 21 2008

Ms. Janet A. St Laurent
Managing Director, Defense Capabilities
and Management
U.S. Government Accountability Office
441 G. Street, N.W.
Washington, DC 20548

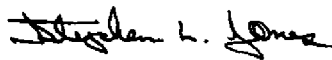
Dear Ms. St Laurent:

This is the Department of Defense response to the Government Accountability Office (GAO) draft report, GAO-08-721R, "MILITARY HEALTH CARE: Review of the President's Fiscal Year 2009 Budget Request for the Defense Health Program's Private Sector Care Budget Activity Group," dated May 9, 2008 (GAO Code 351143).

Thank you for the opportunity to review and comment on the draft report. Overall, I concur with the information contained in the Draft Report by GAO, and believe you have appropriately captured the process the TRICARE Management Activity uses to develop, document, and support Private Sector Care requirements and budget requests. The technical comments are enclosed.

My points of contact on this action are Ms. Farah Sarshar (Functional), who can be reached at (703) 681-6779 and Mr. Gunther Zimmerman (Audit Liaison) who can be reached at (703) 681-4360.

Sincerely,


S. Ward Casscells, MD

Enclosure:
As stated

**GOVERNMENT ACCOUNTABILITY OFFICE DRAFT
REPORT DATED MAY 1, 2008
GAO-08-721R (GAO CODE 351143)**

**MILITARY HEALTH CARE: Review of the President's Fiscal Year 2009 Budget
Request for the Defense Health Program's Private Sector Care Budget Activity
Group**

DEPARTMENT OF DEFENSE COMMENTS

Technical Comments:

1. Page 8, "This process resulted in an initial budget estimate of about \$14.3 billion."
TRICARE Management Activity (TMA) recommends this sentence be changed to:
"This total process resulted in an initial budget estimate of about \$14.3 billion."
2. Page 9, "Department of Defense (DoD) officials compared the results of the economic models with the results of DoD's trend models and decided to reduce its initial budget estimate as a result of this comparison because DoD wanted to use the lower of the two projections." TMA recommends this sentence be changed to: "DoD officials compared the results of the economic models with the results of DoD's trend models and decided to reduce its initial budget estimate as a result of this comparison. DoD believed additional risk could be taken within the Defense Health Program, and therefore chose to accept the lower of the two estimates."

GAO Contacts and Staff Acknowledgments

GAO Contacts

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Acknowledgments

In addition to the contacts named above, key contributors to this report were Tom Conahan, Assistant Director; Laura Durland, Assistant Director; John Bumgarner; Cynthia Forbes; Mae Jones; Ron La Due Lake; Brian Mateja; Lonnie McAllister; Charles Purdue; Joseph Rutecki; and Michael Zose.

Related GAO Products

Military Health Care: Cost Data Indicate That TRICARE Reserve Select Premiums Exceeded the Costs of Providing Program Benefits. [GAO-08-104](#). Washington, D.C.: December 21, 2007.

Military Health Care: TRICARE Cost-Sharing Proposals Would Help Offset Increasing Health Care Spending, but Projected Savings Are Likely Overestimated. [GAO-07-647](#). Washington, D.C.: May 31, 2007.

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(351143)

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